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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on a Case of Ascites from Obstruction in the Portal Vein. Delivered in University College Hospital. By SIR W. JENNER, Bart., M.D., F.C.B., F.R.S., Phys. in Ordinary to the Queen and the Prince of Wales.

To-day, gentlemen, I propose to speak of the case of Robert A., a man who was in the hospital recently, and whose abdomen burst. You may remember that it gave way at the umbilicus with a loud report, and a quantity of fluid came out. He had ascites, and also a considerable amount of gas in his peritoneum. You know quite well, when an abdomen is resonant on percussion, and you find the resonance—*i. e.*, the air within the abdomen—move as you move the patient, that, as a rule, the gas is not in the peritoneum, but in the intestines. In this case, however, the gas was in the peritoneal cavity itself. That is why there was a report when the abdominal wall gave way. The man had had an artificial opening made in his belly—as I shall tell you afterwards—for the purpose of letting out the fluid. It had healed but imperfectly, and, when the gas rapidly accumulated, the weak spot ruptured.

The real causes of the man's troubles were an impediment to the flow of blood through the portal vein, and an impediment to the escape of bile from the hepatic duct. To these two lesions all the others which I shall describe to you were secondary.

Whatever permanently impedes the flow of blood through the portal vein must have, as its necessary result, one or more

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of the mechanical consequences of congestion of the part the blood from which is poured into the portal vein. The blood cannot easily escape from the portal vein; and, of course, all the tributaries of the portal vein are swollen. The consequence is, that when there is impediment to the passage of blood through the portal vein, there is enlargement of the organs, the blood from which passes into the portal vein—as the spleen and the pancreas. The same impediment to the onward flow of the blood may also cause rupture of vessels. The over-distended capillaries burst, and extravasations of blood and hemorrhages occur. Common seats of hemorrhage from this cause are the stomach and the rectum—bleeding piles, hæmatemesis. This man, whose trouble I told you was the impediment to the flow of blood through the portal vein, had repeated attacks of hæmatemesis. Then patients suffering from obstruction to the flow of blood through the portal vein have effusions of serosity from the congested vessels. There is effusion of serum into the cavity of the peritoneum—ascites. This man had ascites. Again, they have "watery fluxes," as they are termed—watery flow from the congested mucous membrane. The mucous membrane of the bowels often suffers from this when it is mechanically congested. The patients have watery diarrhœa. Then thickening of all the congested textures takes place. The coats of the stomach become thickened; the peritoneum becomes thickened; the coats of the intestines become thickened. Again, inflammation, acute or chronic, is very apt to supervene in the congested part. It does not occur constantly, but frequently; so that when there is impediment to the flow of blood through the portal vein it is common to have catarrhal inflammation of the stomach, catarrhal inflammation of the bowels, peritonitis. These are common consequences. Again, ulceration of the congested surface may take place, ulceration of the mucous membrane of the bowels, of the stomach, of the rectum, of all the congested parts. This man had ulceration of the bowel and of the adhesions that had formed in his peritoneum. Then induration of all the textures occurs. Adhesions form between parts that should be free, especially in the peritoneum. Adhesion takes place between the coils of intestine, between the omentum and the intestines, between the intestines, perhaps, and the parietal peritoneum (as we saw in a case the other day), between the liver and the diaphragm, the spleen and the diaphragm, the stomach and the adjacent parts.

As the rule, when there is a *sudden* impediment to the flow through the portal vein, hemorrhage occurs. When the impediment is more slowly developed, serous effusions occur. When hæmatemesis takes place, it generally relieves greatly and at once the congested organs. You find a man's spleen big to-day; he has hæmatemesis, and to-morrow his spleen is greatly diminished in size; its over-distended vessels are emptied, its thickened tissues only remain. You know the close vascular relations between the spleen and the vasa brevia of the stomach.

When I said that some one or more of these results necessarily follow the occurrence of obstruction, I said what was not quite true. I said it intentionally, however; because I wish to fix it in your minds. It is not really *necessary;* but it occurs in the vast majority of cases, in such a large majority that I would fix it in your minds as *the* consequence. It is not the necessary consequence, because a collateral circulation sufficient to relieve the congested vessels may be established. You will remember that there are anastomoses between the inferior mesenteric veins and the hypogastric veins through the inferior hemorrhoidal, and so the blood may come back by the hypogastric vein. Again, the twigs of the portal vein and the veins of the serous covering of the liver open into the diaphragmatic and œsophageal veins, and these little communications may become considerably dilated. Again, adhesions may form between the liver and the diaphragm; new vessels be developed in those adhesions, and these new vessels may be sufficient to considerably relieve the congested portal vein. They open into the diaphragmatic and œsophageal veins. Again, the remains of the umbilical vein

which runs in the ligamentum teres sometimes remain patent. When the portal vein is stopped the remains of the umbilical vein become dilated, and this little channel grows into a big vein, communicates with the mammary veins, and so returns the blood on the surface, and you see the greatly dilated veins there carrying up the blood. You will remember, therefore, when you meet with a case in which you believe that there is disease of the liver causing mechanical impediment to the flow through the portal vein, but in which you do not get the ordinary consequences, what I have spoken of as the necessary consequences, those which you would get in the vast majority of cases—remember, I say, that you may be right in your diagnosis, although you have not the ascites, the diarrhœa, the hæmorrhoids, or the big spleen, because some of the veins of which I have spoken may be performing the extra duty of carrying off the blood from the parts which would otherwise be greatly congested.

Whatever impedes the flow of bile through the hepatic duct or through the ductus communis choledochus must impede the escape of bile from the liver; and whatever prevents the escape of bile from the liver will have jaundice following it, and all the consequences of jaundice.

We find that persons who are the subjects of the impediment to the circulation I have described not only suffer from the mechanical consequences of the impediment, such as the ascites and the hæmatemesis, which are common, and the ulceration of the bowels, which is rare, but they also suffer from defective general nutrition. This man was greatly emaciated. What is the cause of this general malnutrition? First, there is the damage mechanically inflicted on the mucous membrane of the stomach and bowels, and the consequent interference with the digestive process. There is diminished absorption from that cause. Then the mechanically over-distended radicles of the portal vein will be very unlikely to take up anything further. Again, there is the damage to the spleen and pancreas from their long-continued congestion, and the consequent interference with their functions. Again, there is damage to all the organs of the body from the damaged state of the blood consequent on these lesions and on the retained bile. These causes seem amply sufficient to account for the emaciation of the patient. Further, as I told you before, when the abdomen is greatly distended there is sufficient pressure upon the vena cava to interfere with the return of blood from the kidney; there is congestion of the kidney, and then, if the patient survives long enough, a form of Bright's disease and all its consequences.

Impediment to the passage of blood through the portal vein, and of bile through its ducts, is common enough—amongst the commonest diseases; because disease of the liver which has these results is common. But impediment to the flow of blood through the portal vein, and to the escape of bile from the hepatic duct from some condition external to the liver, is rare. It does occur, however. For example, malignant growths or hydatid cysts may press upon the portal vein and the ductus communis choledochus outside the liver. Dr. Stokes has detailed a case of aneurism of the hepatic artery, where it runs, together with the portal vein, in the border of the hepatico-duodenal fold, just above the opening of the foramen of Winslow, and which interfered with the flow of blood through the portal vein.

In the case I am about to narrate to you the impediment was the result of inflammation, induration, and contraction of the cellular tissue of the ligamentum hepatico-duodenale and the cellular tissue in the hilus of the liver—*i. e.*, of the cellular tissue in which the portal vein, and the hepatic, cystic, and common bile-ducts lie. It was the trunk of the portal vein and the trunks of the bile-ducts which were injured and narrowed.

The patient was a man forty years of age, admitted into the hospital on the 9th of February, 1869. As the patient was confused in mind, and could only be made to answer questions with difficulty, the following history was obtained from his sister.

"At about the age of eighteen he enlisted as a soldier and went to India. He remained in India for twelve years, and

returned to England about ten years since. While in India he was frequently in the hospital, as his sister had been told, on account of disease of the liver and spleen. He was a man of intemperate habits, indulging from time to time in 'drinking bouts.'" This is the common cause of cirrhosis of the liver. It is not the only cause, but it is *the* cause, the special cause, to which exceptions are infinitely rare. You will find it mentioned in books, that when making a diagnosis of a case of impediment to the flow through the portal vein, when considering whether it be from cirrhosis, which has that as its great symptom, or whether it be due to some impediment external to the liver, if the patient be a drunkard it is probable that the case is one of cirrhosis. This man was a drunkard, and there was impediment to the flow of blood through the portal vein, but he was not suffering from cirrhosis.

"About six years before admission into the hospital, after one of these debauches of drinking, he vomited a large quantity of blood." So that at that time he had probably—pretty certainly, indeed—impediment to the flow of blood through his portal vein, mechanically induced congestion of his stomach, and as a consequence rupture of the capillaries and hæmatemesis. "The hæmatemesis was repeated on four separate occasions, the last being about twelve months before his admission." No doubt he was relieved by the hæmatemesis. The congestion of the radicles of his portal vein would be relieved by the escape of blood. The loss of blood was not enough to kill him, but merely enough to relieve considerably the congestion of his spleen and of all the radicles of the portal vein.

"After the last attack of hæmatemesis, twelve months ago, the swelling of the abdomen, which had been transient before, became permanent." The transient swellings of his abdomen were probably due to flatulence. The patient had congestion of his stomach and of his bowels, thickening of all the abdominal tissues, interference with digestion, and accumulations of flatus. After the last attack of hæmatemesis the mechanically over-distended vessels relieved themselves by letting out serosity into the cavity of the peritoneum, and permanent swelling, dropsy, ascites was produced. This increased so much that "six months before his admission he was tapped just below the umbilicus, and five and a half gallons of fluid removed" The opening into the abdomen was made a great deal too near the umbilicus. A little ulceration resulted on the inner side of the opening, and obliteration of the umbilical depression ensued. It was a spot where the abdominal walls were weak, and so, when the fluid reaccumulated, the abdominal wall was distended at this spot; a very thin layer of skin covered the fluid beneath, and the skin itself ultimately gave way. He was tapped where he ought not to have been; he should have been tapped lower down, some inches below the umbilicus, a little nearer to the umbilicus than to the symphysis pubis.

"The fluid soon reaccumulated," as it was likely to do. There was a mechanical impediment to the flow of blood through the portal vein; the effusion of serum was the mechanical result; and removing the fluid did not remove the impediment. "Five weeks after the tapping he was nearly as large as he was before the operation; subsequently the distension diminished a little. Five weeks before he came under observation he had a 'fit of drinking' (as his sister called it), which lasted two days. Three days before admission he was seized, 'after tea,' with severe pain in the lower part of the right side of the abdomen. The pain was less after taking some pills; but, as he continued very ill, he was brought to the hospital."

The severe pain in the lower part of his abdomen was, no doubt, the result of perforation of his intestines, which we shall see he had. You will remember that perforation of the intestine is usually announced by sudden severe pain—not always, for now and then pain is absent. All persons of much experience have met with cases where, curiously enough, perforation occurs, I do not know why, without any pain at all. The patient is not aware of having suffered any lesion. The rule, however, is that there is intense sudden pain, with symptoms of collapse,

followed by those of peritonitis. The pills given were probably some opiates to relieve the pain.

On the man's admission into the hospital we noted that he was very thin, that his general nutrition was seriously interfered with. His skin was a dirty, slightly greenish yellow colour. The greenish tint is the tint of long-continued mechanical impediment to the escape of bile from the liver. Hence it is a common tint of cancer of the liver. A person has a gallstone, and a sudden attack of jaundice; the colour is a deep yellow, with no greenish tint in it. But if he has a chronic jaundice, long-continued, his skin has the greenish colour. The veins on the man's hands etc. were small; evidently there was no impediment to the return of blood from the systemic venous system. They were pinkish, from anæmia. The pinkish colour of the vein is evidence of a deficiency in the red corpuscles, probably the result in this man of the interference with the nutrition in general, and perhaps also of the interference with the function of the spleen in particular.

"His abdomen was considerably distended with fluid. The umbilicus also was much distended. No scar could be seen between the umbilicus and the pubes." The fact was that the perforation had been made at the umbilicus. "During the night, at the lower part of the distended umbilicus, the skin gave way with a loud noise." It would not have been a report had there been no air there. "A large quantity, supposed to be about five pints, of stinking fluid escaped. A drainage tube was introduced, and a weak solution of carbolic acid injected. The next day (Feb. 10th) fluid continued to escape from the opening. It was very offensive, and gas escaped with the fluid." We had a full explanation of this afterwards, for we found an opening in his bowel; but remember that all collections of fluid in the vicinity of the bowel are apt to become a little offensive. "The abdomen was very tender. Pulse 108, very weak. Urine dark-coloured, containing one-eighth albumen. The man gradually sank, and died on the 11th at 6 P. M."

There was nothing to be done for him; his mind was gone; his pulse excessively feeble; there was evidence of some injury to his bowel, of a long-continued impediment to the flow of blood through the portal vein, and of bile through the bile-ducts.

After death the cavity of the abdomen contained about two pints of an opaque fluid. The external opening of the umbilicus communicated with the cavity of the abdomen. The liver, stomach, omentum, and intestines were matted together and covered with a thick layer of lymph, so hard and vascular that it must have been of long standing. There were no adhesions between the parietal peritoneum and the intestines and omentum, probably because the man had effusion of serum sufficient to separate the parietal peritoneum from the other parts before adhesions formed. The parietal peritoneum was greatly thickened and reddened, and was evidently the seat of long-continued inflammatory action. The peritoneal coat of the stomach was covered with lymph and thickened, and was the seat of numerous ulcers. The lymph had organized, had become part of the anterior wall of the stomach, and then the seat of ulceration. The posterior part of the bladder was adherent to the sigmoid flexure and the rectum, so that there was no cul-de-sac between the bladder and the rectum. The liver was inseparably united to the diaphragm; its lower edge was above the margin of the thorax.

On separating the adhesions between two of the coils of the small intestine, situated in the right iliac fossa (where the man had felt severe pain during life), an opening was exposed, about the size of a sixpence, out of which fecal matter escaped. In the interior of the bowel, a large ulcer was found at the spot. The mucous membrane around was intensely red, and coated with dirty-yellowish lymph. The situation of the ulcer was in the ileum, about a yard and a half from the cæcum. The peritoneum over the ulcer was destroyed to an extent greater than that of the opening itself, so that the muscular fibres were laid bare as well from the peritoneal as from the mucous coat. As we looked at it *in situ* we thought that the

opening might have been made from the peritoneum into the bowel. This is rare, but we thought it possible. On opening the bowel, however, it was clearly not so, for here the mucous membrane was considerably destroyed; it was destroyed over an area larger than the opening, and larger even than the destruction of the peritoneum. Thus there had been ulceration of the outer side and ulceration of the inner side, but from the congestion of the mucous membrane around, we knew that the perforation had occurred, as it usually does, from within outwards. Several small ulcers were subsequently found in the intestine which had not perforated, but only destroyed the mucous membrane. Thus it was clear that the ulceration had begun in the bowel. It was the result of the mechanical congestion of the bowel. I told you that inflammation of the mucous membrane of the bowel resulted from the mechanical congestion, but that it was catarrhal inflammation. As a consequence of this, deeper-seated inflammation with ulceration may occur, and here we had it so deep that it had perforated the bowel. The mucous membrane around the ulcers was of a deep mahogany colour.

The capsule of the liver was thickened, and the liver itself was too granular, but not contracted; the edge was thick and the tissue broke down easily under pressure. Evidently, although it was not a healthy liver, there was no such disease of the liver-substance as to seriously impede the flow of blood through it. It was not an ordinary cirrhosed liver. The gall-bladder was covered with old lymph, and its coats were thickened; it contained four gall-stones, and scarcely any bile. The cystic duct was completely closed, and the hepatic duct and the branches of the portal vein and the common duct, all the parts in the hilus of the liver, were bound together by old adhesions and a large increase of the connective tissue. This was plainly the centre of the trouble. Here the lymph was the toughest and it was evidently the oldest. Here it was the most perfectly organized, but still greatly contracted, compressing the portal vein, compressing the cystic duct, compressing the ductus communis choledochus. All the branches of the portal vein had their coats greatly thickened, and in one branch —that to the right lobe—was an old clot firmly adherent.

There were four gall-stones in the gall-bladder, but we had good reason to believe that they were not all the gall-stones that had been there. I say, "not all," because their sides were flattened, and they were small gall-stones, and they did not seem to form the whole mass indicated by the peculiar flattening. We thought it probable, from the history of the man, from his having been several times in hospital with something wrong with his liver, that he had had gall-stones before, gall-stones passing down his cystic duct, or his ductus communis choledochus, which had led to inflammation, perhaps to ulceration, and to injury of the parts around. We know that such inflammation and ulceration do sometimes result from the passage of a gall-stone, and that now and then a gall-stone is thrown out by the ulceration into the parts around. We had no evidence here that ulceration had proceeded so far, but we had evidence of inflammation which had become chronic, and had ended in exudation of lymph, the man's habits and the climate he had lived in also perhaps assisting. Lymph thus exuded contracts, and an impediment is established to the flow of blood through the portal vein. Thus, I think that the origin of the patient's trouble, the origin of the inflammation in this particular situation, where it had such a damaging effect upon his health, was the passage of a gall-stone. The liver itself was really scarcely diseased. It contained a good deal of bile from the damming back of bile into it, but the ducts were scarcely, if at all, dilated, and the cellular tissue between the lobules was a little increased. The obstruction to the flow of portal blood to the liver had, no doubt, diminished the formation of bile, and hence the absence of dilatation of the ducts in the liver. The weight of the liver was 3 lb. 7 oz.

The spleen was large and tough, the capsule thickened and adherent; it weighed 1 lb. 10 oz. This was no doubt the result of the mechanically produced congestion.

The mesentery was greatly thickened, coated with lymph such as covered the omentum; this lymph was due probably to the same cause which had led to the thickening of the intestines, to the enlargement of the spleen,—*i. e.*, the mechanical congestion, and the inflammation secondary thereto. The kidneys were enlarged; the right weighed 6 oz., the left 7 oz. The cortical substance was broad and a little speckled with red. Probably the mechanical congestion of the kidneys, assisted by the habits of the man, had given rise to inflammation, and in his cachectic condition to that low form of inflammatory action which is followed by the exudation of a great quantity of protein granules which quickly experience fatty degeneration.

We thus see, pretty clearly, considering how little history of the man we had, the course of his disease from its commencement to his death, and how the one disease, the one condition, followed mechanically upon the other; how the enlargement of his spleen, the vomiting of blood, the effusion into his peritoneum, the ulceration of his intestine, the perforation of his intestine, the distention of his belly, and the bursting of his umbilicus—how all these were the mechanical results of the primary disease, the inflammation of the cellular tissue about the portal vein and the hepatic, cystic, and common bile ducts. The further result of this was changed nutrition, for he was very thin, and evidently his nutrition was interfered with by the damage to the abdominal tissues and organs, consequent on their mechanical congestion, and on the damming back of bile in the blood itself.—*Lancet*, Jan. 8, 1874.

HOSPITAL NOTES AND GLEANINGS.

Tuberculous and Strumous Diatheses.—Dr. WILKS, in commenting on a case of well-marked tuberculosis in Guy's Hospital, made some important remarks on the subject of the tubercular and strumous diatheses. It will be seen that he completely avoided all reference to the vexed question of the nature and varieties of phthisis, but confined himself solely to the consideration of the prevention and the treatment of the disease. He said that two different outward conditions have been included under the term "strumous," so that a person unacquainted with the fact would naturally be at a loss to understand how the small, ill-developed child, with pot-belly, crooked legs, inflamed eyes, enlarged lymphatic glands, and decayed teeth, should ever be developed into a tall, well-formed, and finely-featured young man or woman, who dies of pulmonary consumption. If, however, it be fully realized that the two classes of persons belong to different diatheses, the difficulty at once vanishes. The fact is that tubercular patients, the persons who most frequently die of phthisis, are well made, have a good skeleton framework, straight limbs, a good chest (a little flattened perhaps), good teeth, and an active, intelligent mind. These patients, moreover, as a rule, dislike fermented and alcoholic beverages and fats, but are fond of active bodily exercise. But these proclivities, if greatly indulged in, tend to accelerate the onset of pulmonary consumption; for, be it observed, tubercular disease of the lungs shows itself at that period of life when the respiratory apparatus comes into more active employment. This statement may seem somewhat theoretical, but it will be found a matter of great importance in actual practice. Unfortunately many erroneous views of the nature of tuberculosis are entertained by some members of the medical profession, but more especially by the extra-professional practitioners of the healing art. These erroneous opinions are that tubercular subjects are underbred, small, and have ill-formed chests, which require to be developed by active exercise and the respiration of over-oxygenated air. From these Dr. Wilks entirely dissents, and asserts that the tubercular patient has not ill-developed lungs, which need extra physical exertion to bring them into a normal state, but agrees with the late Dr. Barlow, who held the opinion that tubercle was developed in an organ according to its functional and vascular activity. This opinion is confirmed by the observations of Rokitansky, who has found that

cyanotic patients—that is, those persons in whom there is an habitual preponderance of venous blood—are remarkably free from tubercular disease of the lungs, and that persons who have disease of the heart, or any malformation of the chest which entails a deficient arterialization of the blood, possess a similar immunity from this affection. He even says: "Nay, it is an important fact that with the establishment of a deformity of the spine in the shape of a gibbosity, even when owing to tuberculous caries of the vertebræ, the tubercular crasis is forever rooted out, in consequence of the narrowing of the thoracic spaces." Notwithstanding this, and the well-known fact that many persons who have indulged in great physical exercise, as boating-men and athletes, frequently die of acute phthisis, many writers advise physical exertion for tubercular patients. Quite recently a physician has advanced the hypothesis that tubercle is unconsumed carbon, and recommends physical exercise for its oxygenation and consequent removal. On the other hand, other observers have endeavoured to show that consumptive diseases are aggravated by an excess of oxygen. Whatever may be the value of these theoretical speculations, it will be found, as a matter of fact, that persons suffering from tuberculous disease of the lungs are benefited by rest and injured by severe exercise. Rest, combined with a nutritious diet, will be found to be the best for consumptive patients. It is not necessary to put the patient's chest in a tight jacket, nor to prevent all movement by strappings and plasters, for ordinary repose is sufficient. The beneficial influence of rest to a diseased lung may often be observed in cases where an abscess of the pulmonary tissue has perforated the visceral pleura and evacuated itself into the pleural cavity, giving rise to collapse of the lung and consequent repose. Rest, is, indeed, of more importance than climate, and the determination of this fact is more pressing than the discussion of all the theoretical questions of the intimate pathology of the disease.—*Lancet*, Dec. 6, 1873.

Case of Impacted Fracture of the Anatomical Neck of the Humerus.—The subject of this rare accident was a girl fourteen years of age who was admitted into the Westminster Hospital, under the care of Mr. Cowell, with the history of a blow on the shoulder, produced by a fall from a cart. The appearance presented was, in a minor degree, that of dislocation. There was flattening of the deltoid, prominence of the acromion, some loss of mobility, and a good deal of pain. These were accompanied by some swelling around the joint. The house-surgeon, by whom the patient was seen at her first application at the hospital, thought that he once detected some crepitation. The case was treated by a bandage and rest, but, the diagnosis being obscure, the patient was directed to attend on the day of Mr. Cowell's next visit.

The appearance then presented was the same as recorded above, except that the swelling of the joint was said to have increased. No crepitation was perceptible, and Mr. Cowell called attention to the advisability of always avoiding any disturbance of the parts, since, while crepitation was not generally essential to the diagnosis of fracture, much damage might be done by dislocating an impaction. At first sight this case might be one of partial dislocation, fracture of the glenoid cavity, separation of the epiphysis, or fracture of some portion of the upper end of the humerus, but may be best diagnosed by what is called the negative method—that is, by excluding one injury after another until the possible conditions are reduced to one. First, dislocation is possible, though not probable at the age of this patient; the house-surgeon had already come to the conclusion that none existed, and it was found that the head of the bone could be felt in the glenoid cavity, where it rotated with rotation of the arm. The latter fact showed also that there was no dislocation of the epiphysis—an accident much more likely to happen at the age of this patient—and no fracture of surgical neck of the humerus. The absence of any dislocation is further proved by measurement with a tape carried under

the axilla and vertically over the acromion process, for the measurement was found the same in both shoulders. There was no fracture of the glenoid cavity, for no displacement could be felt, and no crepitation could be perceived on pressing the humerus upwards against the acromion; besides, the external violence had not apparently been sufficient to produce such a fracture. There remains only one condition possible—for the deformity is inconsistent with no lesion at all—and that is fracture of the anatomical neck of the humerus. This is a rare accident, but doubtless exists in the present case. On careful examination with the finger in the axilla, the seat of fracture may be felt, for there had evidently been a slight displacement, but, fortunately for the patient, there was impaction, and a good recovery will probably be the result. Keeping the arm supported and at rest will be all the treatment required, and the patient will be kept in the hospital in order that her progress may be watched.—*Lancet*, Jan. 3, 1874.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Abortive Treatment of Coryza.—Dr. J. S. Prout, of Brooklyn, states (*Med. Record*, Jan. 1, 1874) that he has often been able to arrest the disease in the course of an hour or less, by taking or giving large doses of the officinal tincture of the chloride of iron, 20 or 30 minims, as soon as possible after the cold is "caught." I generally find that in about half an hour there is a decided amelioration of the symptoms, which may be permanent, in which case I take or give no more of the tincture; or the improvement may pass off in two or three hours, in which case the dose must be repeated. This may be required three or four times.

I have had numerous attacks of frontal catarrh, which I have thus caused to abort. I have had the same good fortune with coryzas accompanied by sore throat.

In other cases, perhaps on account of greater severity, or from delay in commencing the treatment, I have not obtained permanent benefit from the use of the tincture. In my hands, therefore, it is not a specific.

A convenient form for extemporaneous prescription is, ℞. Tinct. ferri chloridi, Glycerinæ, ãã ʒiv. M. S. One teaspoonful in a wineglass of cold water, through a glass tube, to be repeated according to circumstances. The glycerine in part conceals the iron taste.

There is a slight diuretic action. I have found no unpleasant effect on the bowels, and only a slight feeling of discomfort, which soon passed off, when it was taken on an entirely empty stomach.

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Administration of Ether.—At the Bellevue Hospital, New York, the administration of potass. bromid. gr. xxx, previous, and the same amount immediately following, or as soon as the patient can conveniently swallow, after the administration of sulphuric ether for the purpose of producing anæsthesia, is now regularly resorted to. The effect is to prevent the vomiting which so commonly follows the use of the anæsthetic.—*Med. Record*, Jan. 1, 1874.

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Picric Acid as a Test for Albumen.—At a late meeting of the Boston Society of Medical Science (*Boston Med. and Surg. Journ.*, October 23, 1873), Dr. Bowditch spoke of a new test for albumen, viz., picric acid, recommended in an article in the March number of Brown-Séquard's Archives, translated from the *Gazette Méd. de Paris*, 1873, p. 122. A drop of the fluid to be tested, urine for example, is allowed to fall into picric acid; it sinks through, and, if albumen is present, leaves a white streak. Dr. Bowditch has not found this so accurate a test as heat or nitric acid: *e. g.*:—

20 cc. of urine + 2 gtt. egg albumen gave slight reaction with heat.

20 cc. of urine + 2 gtt. egg albumen gave distinct reaction with NO_5.

20 cc. of urine + 2 gtt. egg albumen gave no reaction with picric acid.

20 cc. of urine + 4 gtt. egg albumen gave slight reaction with picric acid.

Better results were obtained with picric acid, when a dark back-ground was employed.

National Medical Library.—We regret to learn that Congress, in cutting down the appropriations for the ensuing year, proposes to reduce the amount given to the Museum and Library of the Surgeon-General's Office from the usual sum of 10,000 to 3000 dollars. While we know that the present condition of the national treasury requires a large reduction in the total of the annual appropriations, we are convinced that a wise economy does not demand that this particular appropriation should be reduced to a sum which would barely support the Museum, and entirely stop the progress of the Library. The single fact, apart from many others, that each year adds to the difficulty and expense of completing files of serial publications, and of procuring the older and rare books, should prompt a more liberal and judicious expenditure now with a view of rendering smaller appropriations requisite in the future.

The work, which is now being done in the Library of the Surgeon-General's Office under the direction of Surgeon Billings, of collecting, cataloguing, and indexing, is a labour of inestimable value, and the supply of funds for its continuance will receive the unanimous endorsement of the profession throughout the country.

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Obstetrical Society of Philadelphia.—The following gentlemen have been elected officers of this Society for the present year:—

President—Albert H. Smith, M.D.

Vice-Presidents—John L. Ludlow, M.D., and John S. Parry, M.D.

Secretary—James V. Ingham, M.D.

Treasurer—D. Murray Cheston.

Curator—W. F. Jenks, M.D.

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The Chicago Journal of Nervous and Mental Disease.—Prof. J. S. Jewett and Henry M. Bannister, M.D., announce their intention to commence the publication, in the city of Chicago, of a quarterly journal under the above title. The first number will be issued on or about this date, and the succeeding numbers in the months of April, July, and October respectively.

Archives of Electrology and Neurology.—Geo. M. Beard, A.M., M.D., of New York, proposes to found, with the above title, a journal devoted to the special departments of electricity, in its relations to medicine and diseases of the nervous system.

It is contemplated to issue the first number of the *Archives* early this year. It will be published at first semi-annually.

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Obituary Record.—Died at Cambridge, Mass., Dec. 14, 1873, from nervous prostration resulting in paralysis, affecting the respiratory muscles, and especially the pharynx, after an illness of only a week, Louis John Rudolph Agassiz, aged sixty-seven. Agassiz originally studied medicine, and obtained a degree of M.D., but he never engaged in practice, devoting himself to the cultivation of, to him, the more enticing field of natural history, and with such success that he has been universally regarded as the most eminent of living naturalists.

——— at New York, Dec. 9, 1873, Wm. C. Roberts, M.D., Vice-President of the New York Academy of Medicine, and the author of many medical papers, which display research and erudition, published in various periodicals.

—— in Oswego, Jan. 6, 1874, William R. Bates, M.D., aged 75 years. A practitioner of medicine for fifty-three years.

—— in Burlington, Iowa, November 14, 1873, John Flournoy Henry, M.D., in the eighty-first year of his age. Dr. H. served as surgeon's mate in the war of 1812–14, and was at the battle of the Thames. In 1830, he was elected Professor of Obstetrics in the Ohio Medical College. In 1834 he removed to Bloomington, Illinois, and in 1845 to Burlington, Iowa.

FOREIGN INTELLIGENCE.

Treatment of Non-Parasitic Sycosis.—Dr. Tilbury Fox, in some practical notes on cutaneous subjects (*Lancet*, Dec. 27, 1873), makes the following remarks on this subject:—

No disease, I take it, is more unsatisfactory to treat than the common inflam-

nation of the hair follicles of the beard and whiskers, to which the term sycosis non-parasitica is applied. On the continent, especially in Germany, the practitioner is advised to adopt epilation, and to apply some simple astringent ointment; and there is a great disposition nowadays to regard epilation as the remedy for the disease under notice. The reason for epilating is variously stated. Some affirm that the inflammation in sycosis is caused by a premature development of a new hair in the follicle, and that it is necessary to its cure to rid the follicle of the old hair. Others think that suppuration extends to the root of the hair, and that epilation relieves the tension of the parts and permits the exit of the pus. The first explanation will not bear examination. The second is true in part. In nonparasitic sycosis inflammation travels downwards, and may reach the bottom of the follicle, the root of the hair being bathed in pus, whilst the hair is loosened from its surrounding connections, and lies, as it were, a dead piece of tissue in the follicle. In such cases epilation does but get rid of the loosened hair, and its extraction allows the escape of pus that would otherwise be pent up. But in many cases the inflammation does not proceed to the extent of causing suppuration in the deep part of the follicle, the hairs are not loosened in the follicles, and their extraction gives great pain, and can do no good. Epilation is, therefore, a fit procedure only at a certain stage of sycosis—if the skin is much inflamed, the follicles freely suppurating, and the hairs are thereby loosening or loosened in them.

The treatment which I have found most successful may be summed up as follows: In the early stage, when the follicles are very hyperæmic, saline aperients in persons of full habit; or aperient tonics, such as sulphate of magnesia with sulphate of iron, in those who are debilitated; together with hot fomentations, and simple, soothing applications which exclude the air, locally. When there is free suppuration, the same internal remedies, together with the removal, by epilation, of the loosened hairs from freely suppurating follicles, and the application of mild astringents, such as zinc lotions and ointment; and, lastly, in the subacute or chronic stage, where there is only a suppurating follicle here and there, but mostly a number of indurated tubercles—*i. e.*, follicles thickened by hyperplastic growth of the connective tissue—a course of Donovan's solution, together with, locally, hot fomentation and the application of a weak nitrate of mercury ointment (a drachm and a half to an ounce) night and morning. Of course, for persons of scrofulous constitutions, cod-liver oil and iron are to be given in combination with alterative remedies. I fully admit that the exhibition of Donovan's solution is in great part an empirical proceeding; but I prefer it to any other remedy, and have reason to speak with confidence as to its efficacy in sycosis when employed in the way and at the particular stage above indicated. Lastly, I may add that it is an easy matter to do harm in sycosis by the injudicious use of local irritants, which intensify the hyperæmia and the hyperplastic thickening; and I believe this to be the radical fault in the treatment of sycosis.

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Belladonna Plaster for Vomiting.—M. Guenneau de Mussy recommends for the cure of vomiting a plaster of 12 centimetres (about 4½ inches), in diameter, composed of diachylon plaster 2 parts; theriac plaster 2 parts; extract of belladonna 1 part. This plaster may remain applied for fifteen days without being renewed. By this plaster he has arrested vomiting which had resisted treatment by various means for forty years; and he has also used it successfully as a prophylactic and curative means in sea-sickness.—*La Tribune Méd.*, 14 Dec. 1878.

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Use of Chloral Hydrate in Gonorrhœa.—Dr. Parona has made (*Giornale Ital. della Malat. Ven.*, Oct. 1878) an extended trial of chloral as an injection, both in the gonorrhœa of men and in vaginal blenorrhagia, and speaks of its value as a sedative and also as an astringent. He first tried it in 1870. The strength of the injection is one gramme or one gramme and a half of chloral to 100 grammes of water,

A 2 per cent. solution is too irritating, and is rarely tolerated. The injection is used three times a day, and retained as long as possible. The best time to commence it is when the acute symptoms are subsiding, and it then not only relieves the pain and distress on passing water, but also removes the discharge.—*Med. Times and Gaz.*, Jan. 3, 1874.

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Intravenous Injection of Ammonia in Snake-bite.—Mr. FAYRER calls attention to the following extract from the *Opusculi Scientifici de Felice Fontana*, nearly one hundred years old, which shows that history repeats itself in science as well as in other matters.

"It is very true that several cases of cure of viper bites by the injection of spirits of hartshorn (ammonia) into the veins, have been reported by the Italian papers, and it is also true that these cures appear surprising and almost miraculous from the manner in which they are presented to us; it appears moreover, that certain persons take a quiet pleasure in assuring the public that the true specific against the poison has at last been found, that which I have in vain sought for many years, whilst with philosophical candour I have declared the inutility of my long researches on the subject.—*Indian Medical Gazette*, July, 1873.

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Use of the Aspirators in a Case of Poisoning.—M. DIEULAFOY has published a case communicated to him by Dr. PAUL, of Danville, of an infant poisoned six hours after birth by a dessertspoonful of Sydenham's laudanum. An emetic producing no effect, a sound was introduced into the stomach by the œsophagus, a spoonful of liquid withdrawn, and half a glass of tepid water injected. The symptoms growing rapidly worse, Dr. P. had then at once retested Dieulafoy's aspirator. He injected into the stomach a quantity of black coffee, and then withdrew it; which operation he repeated a dozen times in ten minutes, removing the fluid every time. Other means were also employed, as sinapisms, a purgative enema, followed by one of black coffee, electricity, etc. After thirty-six hours the infant was able to take the breast, and ultimately got quite well.—*L'Union Médicale*, Dec. 20, 1873.

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The Abuse of the Iodides in Secondary Syphilis.—Prof. GAMBERINI, the well-known syphilographer of Milan, has lately called attention to the way in which nowadays the iodides of potassium and sodium are prescribed "in all the forms of secondary syphilis," and deprecates such practice strongly. He says—"The iodides are used as if mercury were no longer of any value. I have examined a large number of cases treated in this way, and have been able to prove that ordinarily the iodides are not beneficial, and that the virtues assigned to them are only the expression of the natural pauses in the course of the syphilis. It is my firm belief that the prolonged use of the iodides as an exclusive remedy in secondary syphilis only serves, as a rule, to impoverish the blood, and so to accelerate the appearance of syphilitic chlorosis." Professor Gamberini recommends those who are sceptical of the truth of his assertions to compare for themselves cases as nearly similar as possible treated with mercury and with the iodides. Is not the warning given above as applicable to English as to Italian medical men?—*Med. Times and Gazette*, December 27, 1873.

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Bloodless Operations.—Dr. G. CLEMENTI, of Naples, claims (*Lancet*, Jan. 3, 1874) for Italian Surgeons the credit of first employing the methods of Esmarch and Dittel, for bloodless operations. Dr. Silvetti, he states, published an account of the latter method in *Gaz. Med. Ital.*, in 1862, and of the former in the same Journal for 1871.

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Aneurism of the Arch of the Aorta.—At a recent meeting of the Liverpool Medical Institution (*Med. Times and Gaz.*, Dec. 13, 1873), Dr. ALEXANDER exhibited a specimen illustrating a fact which does not seem to be generally recognized, although it has been established by a series of very interesting cases by Dr. Axel Key, translated by the late Dr. D. W. Moore, of Dublin, and published a few years since in the *Medical Times and Gazette*—viz., that

aortic aneurisms, however large, and however near to the heart they may be, do not cause enlargement of that organ so long as the semilunar valves are competent. Although in the case in question the aneurism was a large one and near to the heart—occupying a portion of the ascending and transverse parts of the arch—that viscus appeared to be smaller than usual, although its tissue was healthy.

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Pepsinomania.—We learn, from the *Chemist and Druggist*, that Dr. SCHACHT, a councillor and recently president of the Apotheker-Verein, lately read a paper on "Pepsine and Schering's Pepsine Essence." He showed that pepsine only dissolves albumen in presence of free acid, but that a given small quantity of pepsine will effect the solution of any given larger quantity of fibrine, on the same principle as a small quantity of sulphuric acid acting upon alcohol will continue to produce ether. Further, he showed that when the limits of its dissolving capacity are attained, yet by dilution with water and further addition of acid more solution will be effected. He also maintained that a stomach had never been found without pepsine, that the natural pepsine was never entirely destroyed by the process of digestion. From this he concluded that the administration of the artificially obtained product could only be a work of supererogation. It is evident, also, from these premises, that the value of a pepsine cannot be estimated by the quantity of fibrine which it will dissolve, but by the time it occupies in dissolving it. Dr. Schacht's experiments also went to prove that wine or alcohol were the worst possible vehicles for the administration of pepsine. It was probable that the tannin of wine almost entirely hindered the catalytic action of the pepsine. Some experiments were shown to prove that it was much more effective if dissolved in water. Of course, in either case hydrochloric acid is necessary. Dr. Schacht chastised the "pepsinomania" in England, and referred to such preparations as Mr. Lorimer's sauce, which, however, was, he thought, preferable to the pepsine essences or wines. The speaker concluded that the administration of pepsine or any of its preparations was altogether unscientific, on the ground that no stomach had yet been observed in which the remedy was already absent.—*British Medical Journal*, December 27, 1873.

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Cod-liver Oil Loaves.—MM. CARRE and LEMOINE state that of all means of disguising the taste of cod-liver oil its introduction into bread during panification is the best. Every pound of bread should contain seventy-five grammes of oil (five spoonfuls) and about ninety grammes of milk. Small loaves may be made weighing 150 grammes, and containing only two spoonfuls of oil. They are very white and pleasant to look at, and have so little taste of the oil that both children and adults eat them with ease. Thirty-four of these rolls are delivered every day at the Enfants Malades for the use of M. Bouchut's little patients, and the children look out for them with pleasure. They are easily digested, and create no repugnance whatever. In private practice adults make use of them as their ordinary diet.—*Medical Times and Gazette*, Aug. 23, 1873, from *Bulletin de Thérap.*

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Death following the Inhalation of Ether.—The following case occurred at the Royal South Hants Infirmary, and is recorded in the *British Medical Journal* for October 11, 1873.

David N., aged 14, a strumous lad, who had suffered from repeated attacks of corneitis, was admitted an in-patient of the above institution on September 25th, 1873, under the care of Dr. Lake. On Wednesday, October 1st, he was brought into the operating room in order that iridectomy might be performed. When on the table he exhibited considerable alarm, and required some persuasion before he was induced to lie down. Dr. Griffin having taken charge of the pulse, half an ounce of ether was poured on a sponge contained in a cone of spongiopiline, and the latter was closely applied to the mouth and nose. After a few minutes' inhalation, the ether being nearly exhausted, three drachms more were

poured on the sponge. Shortly after commencing to inhale this second quantity he began to struggle violently, getting at length into a state bordering on opisthotonos, his face becoming intensely scarlet. Dr. Griffin then announced that his pulse, which up to this time had been perfectly natural, had become very feeble. The ether was at once discontinued, when, the pulse having improved, Dr. Lake operated, no more ether being administered. At the close of the operation, which occupied only a few seconds in its performance, and before the eye could be bandaged, the pulse became imperceptible, the breathing was suspended, and the countenance livid. The tongue was drawn well out of the mouth and held there; the calves of the legs were vigourously flagellated, and the chest freely slapped with a wet towel. The effect of these measures was to cause the patient to respire freely, to cry out lustily, and to kick about on the table; but this improvement did not last long—probably about a minute. The pulse at the wrist did not return, and the breathing again stopped. Artificial respiration—at first by Silvester's method, afterwards by Marshall Hall's—was then had recourse to; at the same time an intermitted current of faradic electricity was passed in the course of the phrenic nerve; this at first caused strong periodic contractions of the respiratory muscles; but after about ten minutes or a quarter of an hour these ceased to respond to the current, and it became evident that life was extinct. These measures were, however, still persevered with for about three-quarters of an hour. At the necropsy, twenty-one hours afterwards, the brain was found to be healthy, and not much congested. The right cavities of the heart were full of dark fluid blood, but the left cavities contained only about a drachm of a similar fluid. The valves were healthy. The muscular structure, although somewhat flabby, presented no decided evidence of fatty degeneration. The lungs were congested, and of a somewhat bright red colour. The other organs were healthy.

Dr. Henry J. Bigelow, of Boston, thus interprets (*Boston Med. and Surg. Journ.*, Nov. 20, 1873) this case:—

"A feeble boy was etherized. During this process, though only partially narcotized, he was very completely asphyxiated, and, when nearly dead, was operated on without efforts at resuscitation. When at last his absolute prostration awakened serious alarm, he was vigourously flogged with the view of restoring his exhausted strength; and under this active stimulus was excited to a final muscular effort which expended and extinguished his flickering vitality. I believe that such a death might have occurred without the ether."

Dr. Bigelow unhesitatingly submits asphyxia as the primary cause of death, and offers the following explanation:—When we say "death from chloroform," we mean death by a shock or poison peculiar to chloroform, even when inhaled by a healthy person, under the most favourable circumstances, with abundance of air, and with every precaution; sometimes occurring at the beginning of anæsthesia undertaken for a trivial operation, almost as if by prussic acid; the sudden failure of a normal pulse indicating that the patient is beyond recovery.

"With ether, I believe this to be simply impossible. It always acts slowly, never depressing the vital powers suddenly, or beyond recovery, without fair warning by the pulse in time to avert danger by the simple expedient of filling the lungs with unadulterated air."

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The Fog.—The recent fog in London will long be remembered as one of the most disastrous this generation has known. To persons with cardiac and respiratory disease it has in numerous instances proved fatal. The accidents were, moreover, sufficiently numerous, and in several instances in the East of London deaths by drowning in the canal and river occurred. From inquiries we have made at the principal hospitals we learn that at the Charing Cross hospital there were thirty or forty cases of accidents, and that the patients in the hospital suffered severely, especially those affected with heart and lung disease. The death-rate during the days the fog lasted was unprecedented—in fact, higher than since the hospital has been established.

In one day six post-mortem examinations were made. At St. Thomas's a man was brought in dead from having fallen from his cab. He had a scalp wound and bruises on the scalp; and a boy was brought into the hospital burnt in the face with a torch. At King's College Hospital there were two cases of accident—one a crushed hand, another a crushed toe. At Guy's there were four. A man at work upon the leads of a city warehouse in the fog walked off the building, and fell headlong to the ground. He fractured his skull, and was taken to Guy's, where he died shortly after admission. A fog signal-man was run over. At St. Bartholomew's there were no accidents but an increase of in-patients. From the Royal Free we have reported the accelerated death of in-patients. At the Middlesex a case of fractured fibula was received, and a patient suffering from concussion and scalp wound from falling off a mail-cart. At St. Mary's the in-patients are reported to have suffered severely. At St. George's there was a case of burn from a torch, and a case of bruise from falling over the park railings. The in-patients at St. George's and also at the Westminster Hospital are reported to have suffered severely.—*Med. Times and Gaz.*, Dec. 20, 1873.

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Memorial of the late Sir James Y. Simpson.—At a meeting of the Committee of Subscribers, for a memorial of the late Sir J. Y. Simpson, held in December last, it was unanimously resolved to commission Mr. William Brodie, R. S. A., to execute a statue in bronze, to be erected in some suitable site in Edinburgh.

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Cancer of the Liver.—At a late meeting of the Liverpool Medical Institution, Dr. Glynn exhibited a large cancerous tumour of the liver. The tumour, although undoubtedly malignant, was single, occupying almost the whole of the left lobe, which was greatly enlarged; the increase in size was entirely upwards and posteriorly, the edge of the liver never having descended below the margin of the thorax; a large thrombus had been formed in, and completely blocked up, the portal vein, causing extensive ascites during life; and almost up to the period of death there had been an absence of any very severe symptoms. With reference to the last point, the president (Dr. Cameron) remarked on the frequency with which, in extensive cancerous disease of the liver, there was a similar absence of symptoms; and Dr. Carter mentioned that at the first meeting of the Society, in the previous year, he had exhibited a liver universally infiltrated with cancerous nodules, and weighing nearly eleven pounds, which he had removed from the body of a patient who had died after a few days' illness in the Royal Northern Hospital, and who, almost up to the time of his admission, had been working as a labourer on the hospital building—as he himself said, without any inconvenience or consciousness of ill health.—*Med. Times and Gaz.*, Dec. 18, 1873.

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Journal de Thérapeutique.—A new French journal with the above title is announced to appear on the 1st of January under the editorial management of Dr. Gubler, assisted by Drs. Bordier and Labbé.

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Bulletin de Thérapeutique.—This very successful journal has been sold by the executors of its late proprietor, Dr. Bricheteau, for 115,000 francs, to Dr. Dujardin-Beaumetz, who has added to the editorial staff three members of the faculty, viz., Profs. Béhier, Bouchardat, and Dolbeau.

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Obituary Record.—Died, in London, on 24th December, aged forty-seven years, of heart disease, Francis C. Webb, M.D. Edin., for some time past sub-editor of the *Medical Times and Gazette*, and since the temporary withdrawal of Dr. Druitt, on account of ill-health, editor in charge.

—— in London, Dec. 18, 1873, from a chronic abscess in the posterior mediastinum, and secondary pyæmic abscesses in brain, Henry W. Fuller, M.D., Senior Physician to St. George's Hospital, and the author of a valuable treatise on Rheumatism and Gout, and on Diseases of the Heart and Lungs.

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